STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005009	A. BUILDING: _____ B. WING _____	C 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MEMORIAL HOSPITAL	1220 MISSOURI AVE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was a State investigation of 1 hospital complaint. Complaint: #IN00152816 Substantiated: No deficiencies related to allegations cited. Survey Date: 8/22/14 Facility #: 005009 Surveyor: Trisha Goodwin, R.N. Public Health Nurse Surveyor Clark Memorial Hospital is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical Plant, maintenance, and environmental services. QA: claughlin 08/29/14 .	S 000		